

**Connecticut State Innovation Model (CT SIM) – Equity and Access Council (EAC)
Summary of Draft Recommendations for EAC Consideration on March 12, 2015**

Introduction

The CT Healthcare Innovation Steering Committee (HISC) has charged the EAC with evaluating the risk of, and recommending methods to safeguard against, under-service or patient selection that could occur as a byproduct of the transition from fee-for-service provider reimbursement to payment models that reward providers for managing total cost and quality of care.

The EAC has explored nine “solution areas” in which the state, payers, providers, or other entities could build such safeguards into the healthcare financing and delivery system in concert with other reforms. At its meeting on March 12, 2015 the EAC will consider adopting recommendations in two of these areas. Please see materials at www.healthreform.ct.gov for more background on these solution areas.

Recommendations that are adopted in EAC meetings will be placed in a draft report, which, once complete, will be subject to a review in which the EAC considers each recommendation again, this time in the context of the full slate. The report, once the EAC adopts it, will be submitted to the HISC for its consideration, feedback, and adoption.

The EAC, like other components of the SIM governance structure, exists to surface effective solutions and to create alignment among key stakeholders in support of the goals established in Connecticut’s State Healthcare Innovation Plan. Its recommendations are intended to inform the actions of policymakers as well as those who purchase, provide, insure, and utilize healthcare in Connecticut. They are not binding on the executive branch of government, on any of the EAC’s members, or on the organizations they represent.

Area 1: Patient Attribution

Background

The method that a payer uses to attribute patients to a provider has implications for the risk of patient selection that could occur as a byproduct of shared savings contracts. Patient attribution methodology may also affect patients’ access to providers. The EAC explored a number of contract design features that might prevent inappropriate patient discontinuation, promote patient choice and engagement in one’s own care decisions, and incent ACOs to proactively manage care for some of the most challenging patient populations.

Recommendations

Recommendation #1: Patients should be able to identify their primary care provider through an attestation (designation) process as a primary attribution technique. In the event that the chosen provider’s panel is closed, the patient will either select a different provider or be attributed through the plurality of visits process. Patients who choose not to pick a primary care provider through attestation will be assigned based on the plurality of their visits.

Recommendation #2: Patients should be made aware that when they are attributed to a physician who is participating in a shared savings program. They should also be made aware of the program’s goals and the role of the patient and the provider in achieving those goals.

Recommendation #3: Traditional attribution methodologies assume patients are actively seeking care from a provider. They will not attribute patients who seek care only in other settings (e.g., an emergency department or

urgent care center). Payers should give strong consideration to using other settings of care for secondary attribution in order to attribute patients and encourage a provider to take accountability for their care.

Recommendation #4: Prospective attribution will generate provider and patient awareness, promote effective care management and coordination, and protect against patient discontinuation. These benefits outweigh any potential risk of under-service that might be heightened by prospective assignment.

Recommendation #5: An end-of-year retrospective reconciliation should be used to un-attribute prospectively attributed patients who no longer qualify (based on plurality of visits or patient attestation) to be attributed to a physician. This process should incorporate sufficient safeguards to ensure patients are not inappropriately discontinued during the performance year.

Area 2: Cost Target Calculation

Background

The method that a payer uses to define the cost target against which actual cost of care is measured to calculate savings has implications for the risks of under-service and patient selection that could occur as a byproduct of shared savings contracts. The EAC explored the role of cost benchmarking, risk adjustment, and additional contract features (e.g. truncation of claims, use of supplemental PMPMs for complex populations) in minimizing these risks and maximizing the likelihood that providers will seek to manage care – and will have the right resources to do so – for particularly challenging and underserved patient populations.

Recommendations

Recommendation #1: Rewarding providers for improving cost performance year over year will minimize pressure on historically lower performers to achieve a fixed cost benchmark that is unattainable using clinically appropriate cost management methods. In turn, this may reduce the risk of under-service and patient selection. Use of a historical benchmark provides an inherent incentive to improve; a control group benchmark does not. When payers utilize a control group cost benchmarking methodology, they should consider rewarding providers based on their degree of cost improvement over the prior year, in addition to their performance against the group.

Recommendation #2: When a historical methodology is used to set a cost benchmark, a concurrent control group benchmark should also be calculated to evaluate the need to adjust for any systemic factors that substantially increased the cost of caring for the population – or a sub-population – beyond what was predicted for that year.

Recommendation #3: Use of a PMPM payment should be considered for patients who have socioeconomic attributes that are demonstrated to increase resource-intensiveness of providing care but that are not well-captured by purely clinical risk adjustment methods.

Recommendation #4: In the long-term, data collected for under-service and patient selection monitoring purposes should be utilized to identify populations for which the current risk adjustment methodologies are not leading to improvements in equity and access, and should be adjusted accordingly using clinical or non-clinical factors.

Recommendation #5: Truncating costs based on a percentile cutoff will eliminate any incentive to withhold required care after a catastrophic event in an effort to minimize overall costs, and will help to keep providers focused on managing the more predictable types of utilization that value-based contracts seek to improve.